2009

STATE OF CALIFORNIA

ASSISTED LIVING WAIVER

CARE COORDINATION AGENCY

PROVIDER HANDBOOK

DHCS

California Department of
HealthCareServices

Assisted Living Waiver
2009
Care Coordination Agency
Provider Handbook

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1. INTRODUCTION

Welcome and congratulations! You are now a provider of Medicaid Waiver Care Coordination for the Assisted Living Waiver (ALW) administered by the Long-Term Care Division, Monitoring and Oversight Section, California Department of Health Care Services. Thank you for joining our team!

As a new partner with DHCS, we want to make sure you know and understand some of our often-used terms: "DHCS" refers to the California Department of Health Care Services — one of several Departments within the California Health and Human Services Agency. The mission of DHCS is to protect and improve the health of all Californians.

The Assisted Living Waiver, sometimes referred to as the ALW, offers Medi-Cal eligible individuals the opportunity to receive necessary supportive services in less restrictive and more homelike settings.

You are an important part of the ALW program. You and other service providers enable individuals to maintain independence in their own homes —their units in a Residential Care Facility for the Elderly (RCFE) or apartments in a publicly-subsidized housing (PH) setting.

Along with your ALW clients, you will work with RCFEs, and Home Health Agencies (HHAs). Licensed RCFEs provide the Assisted Living services and HHAs provided Assisted Care services in the PH setting. The components of the Assisted Living services and Assisted Care services are quite similar. They both include personal care services (including assistance with ADLs and IADLs as needed), chore services, medication oversight and administration, as required, intermittent skilled nursing, and social and recreational programming.

In addition to RCFEs and HHAs, you'll also work with other agencies that provide environmental accessibility adaptations.

In order to improve the readability of this Handbook, we've taken some shortcuts. Client/residents are usually referred to simply as residents but may also be called clients, beneficiaries or recipients. In any case, there is no real difference. For simplicity sake, we have also abbreviated Assisted Living Waiver services by simply saying AL Waiver program or ALW.

2. PURPOSE, BACKGROUND AND PROGRAM SPECIFIC INFORMATION

A. Overview

(1) Introduction

This chapter describes the California's Medi-Cal Assisted Living Waiver (ALW), Program and specifies the authority regulating waiver services, the purpose of the program, resident eligibility criteria, and provider qualifications.

Information regarding the ALW can be found on the California Department of Health Care Services' (DHCS) ALW webpage: http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx

(2) Enabling Legislation and Legal Authority

The California Medicaid Assisted Living Waiver was initially authorized as a three-year demonstration program by Assembly Bill 499 (Aroner) (Chapter 557, Statutes of 2000).

Medicaid Home and Community-Based Services (HCBS) waiver programs are authorized under Section 1915(c) of the Social Security Act and are governed by Title 42, Code of Regulations (C.F.R.), Part 441.300. The Assisted Living Waiver has been renewed and approved by the Centers for Medicare & Medicaid Services for five years, 2009 through 2013.

B. What is the Assisted Living Waiver (ALW)?

(1) Background

The ALW is a program that has demonstrated that assisted living services reimbursed by Medi-Cal can be provided in a manner that assures the safety and well-being of beneficiaries and that the provision of these services constitutes a cost-effective alternative to long-term placement in a nursing facility.

There are two implementation models for this Program.

- In the first model, Assisted Living services are provided to participants who reside in RCFEs. In this model, services are delivered by the RCFE staff.

- In the second model, Assisted Living services are provided to participants who reside in publicly subsidized housing. In this model, services are delivered by Home Health Agency staff.

The ALW has been financed using a Medicaid (Medi-Cal) Home and Community-Based Services (HCBS) waiver.

(2) Purpose

The goal of this program is to enable Medi-Cal eligible seniors and persons with disabilities who require nursing facility care, but can safely and appropriately be served outside of a facility, to remain in or relocate to community settings. This goal is accomplished by providing an assisted living benefit and other services.

(3) Key Program Components

Assisted Living is designed to meet residents' personal care, support and health care needs while maximizing their autonomy and independence and preserving their ability to exercise choice and control. By responding to their particular and changing needs, assisted living supports residents as they age in place and minimizes their need to re-locate or be admitted to a nursing facility.

- ALW benefits include the assisted living services, or assisted care services, Care coordination and access to a fund that pays for environmental accessibility adaptations.

Assisted living (or care) services will be provided to all enrolled clients and will be delivered in either an RCFE or in a PH apartment. In the RCFE, staff will provide the Assisted Living services. In PH residences, Assisted Care services will be provided by a Medi-Cal licensed Home Health Agency (HHA).

All HCBS waiver programs must meet the following two requirements:

- ✓ All enrolled clients **MUST** demonstrate needs that would result in placement in a nursing facility were it not for the provision of ALW waiver services; and
- ✓ The cost of providing care **CANNOT** exceed the cost of care that would have been provided had the client been a patient in a Nursing Facility (NF).

C. Who Can Receive Services?

(1) Introduction

The ALW offers eligible persons a choice between entering (or leaving) a NF ***or*** receiving necessary supportive services in a less restrictive and more home-like setting. Medi-Cal can reimburse providers for services they deliver to eligible Medi-Cal recipients who are enrolled in the ALW and reside in ALW participating sites.

(2) Eligibility Criteria

There are certain eligibility criteria that must be met in order to receive services as an ALW client. The eligibility criteria are:

(a) Age 21 or older;
(b) Enrolled in the Medi-Cal program (See the Medi-Cal section below);
(c) Have care needs equal to those of Medi-Cal funded residents in NFs (See Nursing Facility Levels of Care section below);
(d) Willing to live in an AL Waiver setting as an alternative to a nursing facility.
(e) Facilities approved to participate in the ALW must be located in one of the counties providing ALW services as indicated::
    (i) Sacramento, San Joaquin and Los Angeles Counties,
    (ii) 2009, Sonoma and Fresno Counties,
    (iii) 2010, San Bernardino and Riverside Counties,
    (iv) 2011, Contra Costa and Alameda Counties.
    (v) 2012, San Diego and Kern Counties
    (vi) 2013, Placer and Shasta Counties
(f) Able to be served within the ALW cost limitations and,
(g) Able to reside safely in this setting.

ALW services will not be furnished to individuals who are inpatients of a hospital, Nursing Facility, or Intermediate Care Facility for the Mentally Retarded.

(3) Medi-Cal Application Responsibilities

Individuals who have not applied for and been determined to be eligible for Medi-Cal at the time they need ALW services must complete, or have a designated representative complete, and submit a Medi-Cal application to their local county social service office (listed http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx) Individuals already receiving SSI/SSP payments are automatically eligible for Medi-Cal as arranged by the local Social Security Administration office.

More information about Medi-Cal, including answers to frequently asked questions, is available at this DHCS website: http://www.dhcs.ca.gov/individuals/Pages/default.aspx

(4) Nursing Facility Levels of Care

There are two types of nursing facilities, those licensed for level A patients and those licensed for level B. Nursing Facility A (NF-A) facilities are Intermediate Care Facilities (ICF); Nursing Facility B (NF-B) facilities are Skilled Nursing Facilities (SNF). The Level of Care (LOC) standards for NF-A and NF-B facilities are set forth in Title 22 of the California Code of Regulations.

ALW Care Coordination Agencies (CCAs) determine an applicant's functional eligibility for the program by verifying that the individual meets the LOC determination. That is the applicant requires the level of care that is delivered in either a NF-A or NF-B facility. The initial evaluation and periodic reevaluations of the need for nursing facility LOC are conducted to establish that there is a reasonable indication the client would be eligible for nursing facility placement but for the availability of home and community-based services.

Individuals requiring one of these levels are distinguished as follows:

(a) Individuals Needing Nursing Facility Level A (NF-A)
- (i) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care
- (ii) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
- (iii) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.

(b) Individuals Needing Nursing Facility Level B (NF-B)
- (i) Require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses or the equivalent thereof.
- (ii) Do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.

(5) Clients Who Cannot be Safely Maintained in the Community

Some potential participants may require more care than can safely be provided through the ALW. The following conditions automatically render the individual ineligible for the project:

(a) Stage 3 or Stage 4 pressure sores (pressure ulcers)

(b) Nasogastric tubes
(c) Ventilator dependency
(d) BiPap dependency without the ability to self-administer at all times (BiPap is a non-invasive form of mechanical ventilation)
(e) Coma
(f) Continuous IV/TPN therapy (TPN - Total Parental Nutrition is an intravenous form of complete nutritional sustenance)
(g) Wound Vac therapy (A system that uses controlled negative pressure, vacuum therapy, to help promote wound healing.)
(h) Active communicable tuberculosis
(i) Restraints, except as permitted by the licensing agency for RCFE residents.
(j) For the public housing setting only, individuals who require a two-person transfer are not eligible for the assisted living waiver.
    (i) In this setting, potential beneficiaries must be able to be mobilized to a chair or wheelchair with the assistance of not more than one attendant.
    (ii) While this provision does not restrict the use of more than one staff member to safely mobilize or transfer a resident when providing routine care, clients may not require transfer or mobility assistance from more than one person in the event of an emergency requiring evacuation.

D. Who Can Provide ALW Services?

(1) Requirements for ALW Service Providers

Medi-Cal contracts with RCFEs, Home Health Agencies, and CCAs to provide services to ALW clients. Other providers of waiver benefits may contract directly with Medi-Cal **or** they may choose to submit invoices through the beneficiary's CCA.

All service providers, whether or not they choose to contract with DHCS or submit invoices through a CCA, are required to meet minimum standards in order to participate in the ALW.

Provider qualifications are verified during the application process and during provider review by DHCS.

(2) Minimum Requirements for Care Coordination Agencies

(a) Agency Experience and Staff

(i) CCAs must have five years of experience providing care coordination, which includes the following activities: conducting assessments, developing care plans, arranging for and monitoring service delivery, maintaining progress

notes and case records, conducting quality assurance reviews, and collecting data.

(ii) CCAs must have R.N. Care Coordinators and Social Service Care Coordinators on staff.

(b) Staff Education

(i) R.N. Care Coordinators must have and maintain a current, unsuspended, un-revoked license to practice as an R.N. in CA and a minimum of two years experience working in a related nursing field

(ii) Social Service Care Coordinators must have a bachelor's or master's degree in social work, psychology counseling, rehabilitation, gerontology, or sociology and a minimum of three years work in a related healthcare field.

(c) CCAs must enroll as a Medi-Cal Assisted Living Waiver provider.

(d) Agencies must have mandatory in-service training programs for their staff.

(e) Agencies must have a process for soliciting and/or obtaining feedback from clients regarding their satisfaction with service.

(f) Agencies must work in conjunction with the Money Follows the Person (MFP) program in California to assist with the successful placement into the ALW of persons identified by the MFP who choose the ALW.

(g) Agencies must have a quality assurance program to track client complaints and incident reports.

(f) Agencies must maintain a service record for each client. At a minimum, the record must contain all required forms, completed assessments, signed care plans (ISPs), and progress notes. Agencies must agree to make these records available to DHCS for audit.

(g) Agencies must have contingency plans to deliver services in the event of a disaster or emergency.

(h) Staff must agree to collect data as specified.

(3) Minimum Requirements for Providers Who May Submit Invoices to Care Coordination Agencies

(a) Environmental Accessibility Adaptation

(i) Vendors for modification work that costs in excess of $500 must be licensed contractors who are bonded and insured.

(ii) Handymen who perform modification work that costs less than $500 must have a local business license.

3. COVERED SERVICES, PROGRAM REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS

A. Introduction

This chapter describes the services covered under the ALW.

B. Description of ALW Benefits

ALW waiver benefits include:

- Care coordination
- NF Transition Care Coordination
- Assisted care or assisted living services (depending on the participants place of residence), and,
- Environmental accessibility adaptations.

(1) Care Coordination

Every ALW enrollee has a Care Coordinator. Care coordination includes identifying, organizing, coordinating, and monitoring services needed by a recipient. The Care Coordinator assists waiver recipients in gaining access to waiver services, state plan services and other community resources. Services provided or coordinated by Care Coordinators include:

(a) Enrolling clients;

(b) Conducting assessments using the ALW Assessment Tool;

(c) Determining each client's level of care (i.e. tier)

(d) Developing Individualized Service Plans (ISPs) using the ALW ISP Form;

(e) Arranging for Waiver, State Plan and other services as determined necessary by the assessment and as documented on the ISP;

(f) Frequent monitoring of service delivery;

(g) Helping transition clients from nursing facilities to RCFEs or a PH setting;

(h) Maintaining progress notes and case records for each enrolled client;

(i) Adhering to the prescribed schedule of client contact;

(j) Receiving complaints from clients, families or friends and forwarding complaints to DHCS;

(k) Reporting all signs of abuse or neglect to DHCS and the Ombudsman (if abuse or neglect occurs in an RCFE) or DHCS and APS (if abuse or neglect occurs in PH); and

(l) Arranging for payment for vendors who opt not to bill Medi-Cal directly.

(See Section 4. B for a description of the care coordination process)

(2) NF Transition Care Coordination

Contracted Care Coordinators may provide NF Transition Care Coordination for **up to 180 days prior** to successfully transitioning an individual from a skilled nursing facility into the Assisted Living Waiver program and a setting where assisted living services will be provided. Care Coordinators may only bill for this service after the client has been enrolled in the ALW.

(3) Assisted Living Services

Services provided or coordinated by RCFE staff include:

(a) Developing a Care Plan for each resident detailing, at a minimum, the frequency and timing of assistance. Residents must be a part of the development process and must sign the Care Plan;

(b) If appropriate based on Care Plan, the Contracted Care Coordinator will physically observe private rooms that are required to be provided by the RCFE waiver provider that include:
   a. Private or semi-private full bathroom (shared by not more than two beneficiaries);
   b. Shared common space, such as a dining room, parlor or common activities center that may also serve as a dining room;
   c. Kitchenette, equipped with a refrigerator, a microwave (or cooking appliance) and adequate storage space for utensils and supplies;

(c) Providing personal care and assistance with ADLs sufficient to meet both the scheduled and unscheduled needs of the residents;

(d) Washing, drying and folding all laundry;

(e) Performing all necessary housekeeping tasks;

(f) Maintaining the facility;

(g) Providing three meals per day plus snacks. Food must meet minimum daily nutritional requirements. Special diet needs must be accommodated;

(h) Providing intermittent skilled nursing services as required by residents;

(i) Providing assistance with the self-administration of medications or, as necessary, having licensed nursing staff available to administer medications;

(j) Providing or coordinating transportation;

(k) Providing daily social and recreational activities; and

(l) Providing an emergency response system that enables waiver beneficiaries to summon assistance from personal care providers.

RCFE staff may arrange for other service providers to meet unique or special needs of the client, but the care provided by these other entities supplements the services provided by the primary service provider and does not supplant it. Examples of such services are: physical therapy, speech therapy, and occupational therapy.

(4) Assisted Care Services

Services provided or coordinated by Home Health Agency staff include:

(a) Developing a Care Plan for each resident detailing, at a minimum, the frequency and timing of assistance. Residents must be a part of the development process and must sign the Care Plan.

(b) Providing personal care and assistance with ADLs sufficient to meet both the scheduled and unscheduled needs of the residents;

(c) Washing, drying and folding all laundry;

(d) Performing all necessary housekeeping tasks;

(e) Providing three meals per day plus snacks. Agencies may, in conjunction with the public housing site, coordinate the provision of communal meals. If communal meals are provided, residents are

responsible for funding the purchase of raw food. Regardless of where the meals are served, food must meet minimum daily nutritional requirements and special diet needs must be accommodated;

(f) Providing intermittent skilled nursing services as required by residents;

(g) In accordance with State law, providing assistance with the self-administration of medications or, as necessary, administering medications;

(h) Providing or coordinating transportation;

(i) Providing or coordinating daily social and recreational activities; and

(j) Providing an emergency response system that enables waiver beneficiaries to summon assistance from personal care providers.

(5) Environmental Accessibility Adaptations

(a) Environmental accessibility adaptations are physical adaptations to the home, required by the client's ISP, which are necessary to ensure the health, welfare and/or safety of the client, or which enable the client to function with greater independence in the home, and without which the client would require institutionalization.

(b) Such adaptations may include the installation of ramps (in the client's unit or in the common areas of the residence) and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the client.

(c) Adaptations or improvements to the home that add to the total square footage of the living space or are of general utility, and are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are not covered.

(d) This service is only available to clients who live in public housing and are changing residences or who have experienced a change in functionality that requires additional accommodation. In the event that the client relocates to another Assisted Living Waiver unit, the client may access this benefit a second time. Re-access to the benefit is limited to once every twelve (12) months.

The maximum amount of this benefit is $1,500. These funds cannot be used for clients who reside in an RCFE.

(6) Medi-Cal State Plan Services

ALW participants are entitled to use all Medi-Cal state plan benefits including all primary, preventive, specialty, acute care and pharmaceutical services. Participants are not expected to use in-home supportive services as these services are being provided through the Assisted Living or Assisted Care Services.

Participants requiring short-term placement in a facility to recuperate from an acute episode will return to their primary residence and continue enrollment in the ALW. Participants requiring long-term placement in a skilled nursing facility will be terminated from the project.

(7) Other Community Resources

Care Coordinators are expected to refer ALW enrollees to, or arrange for, enrollees to participate in services funded through the Older Americans Act or other reimbursement sources as determined to be necessary by the ALW Assessment. Examples of appropriate services might include legal services, money management services, or friendly visiting.

C. Program Requirements

(1) Resident Privacy

(a) ALW benefits are furnished to clients who reside in private residency units. While all waiver clients must be offered a private unit, clients may ask to share a residence with a roommate of their choice.

- (i) Sharing a residence may not be a requirement of program participation.
- (ii) The ISP must reflect the choice of the resident to share a residence.
- (iii) Residents who wish to share a residence must initiate and submit their request to their Care Coordinator who will forward the request to the housing provider. If the client is cognitively impaired, the request may be initiated and submitted to the Care Coordinator by the resident's responsible party.

(b) All residences shall have kitchenettes and private or semi-private bathrooms not shared by more than one other client. RCFEs with a licensed capacity of fewer than seven beds are not required to

provide kitchenettes, provided that residents have access to a common kitchen area at all times.

(c) The client has a right to privacy. Residences may be locked at the discretion of the client, except when a physician or mental health professional has certified in writing that the client is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with the fire code.)

D. Exclusions

Payments made by Medi-Cal for Assisted Living Services or Assisted Care Services may not be used to pay for rent, the purchase of food, or the cost of furnishing units with kitchenettes. Rent and food are paid for by the residents.

The room and board costs charged by an RCFE to an SSI recipient cannot exceed the amount of the SSI check **MINUS** the Personal Needs Allowance.

E. Leave of Absence and Discharge

(1) Introduction

AL Waiver recipients must reside in a setting served by an ALW Primary Service Provider in order to receive AL Waiver services. A recipient that is not a resident of either an AL waiver contracted RCFE or a PH setting served by a contracted HHA cannot receive AL Waiver services even if all other eligibility criteria are met.

(2) Leave of Absence

If ALW recipients are absent from their primary residence (e.g., public housing setting or RCFE) for more than 24 hours for health or personal reasons, AL Waiver Services are not being provided and may not be billed.

(3) Discharge from an RCFE or PH

If the RCFE initiates discharge of an AL Waiver recipient, the discharge must be done in accordance with the Community Care Licensing requirements and in cooperation with the client's Care Coordinator.

If the PH setting evicts an AL Waiver recipient, the eviction must be done in cooperation with the client's Care Coordinator and in accordance with

the terms of the lease and HUD regulations, if the building is governed by HUD requirements.

(4) Move to another ALW Setting

If the recipient requests to move or is moved from one AL Waiver setting to another AL Waiver setting, the discharging AL Waiver service provider will assist in coordinating the placement, and the recipient will remain eligible to receive AL Waiver services in the new setting.

Any time a change in AL Waiver service provider is necessary, the change must be coordinated with the recipient's Care Coordinator.

(5) Move to a Non-ALW Setting

Changes in residence for an AL Waiver recipient must be coordinated with the Care Coordinator. If it appears that a nursing facility or other placement is necessary, the facility must coordinate with the Care Coordinator and jointly develop a plan to seek an appropriate placement.

F. Termination of Assisted Living Waiver Services

(1) Introduction

In most cases, AL Waiver recipients must be given a written 10 day advance notice of termination that includes information on their right to request a fair hearing. This notice should not be confused with any notice required by applicable law to pursue eviction of a resident from public housing or the 30-day written notice that is required to evict a resident from an RCFE. A resident who is terminated from the ALW is not prohibited from remaining in the PH setting or residing in the RCFE if the resident meets RCFE admission and retention criteria.

(2) Criteria for Denial or Termination of ALW Services

(a) Enrollment in the ALW may be denied or terminated when any one of the following circumstances occur:

(i) Client elects in writing to terminate services;
(ii) Client elects to receive services through a different Home and Community-Based Services waiver program;
(iii) The client's health care needs no longer meet the level of care necessary to qualify for the Assisted Living Waiver program;
(iv) The client's Medi-Cal eligibility changes such that s/he is no longer eligible to participate in the waiver;

(v) The cost of waiver services plus state plan benefits exceeds the cost of care in the alternative facility setting;

(vi) The client is unwilling or unable to comply with his or her Individual Service Plan;

(vii) The waiver service provider is unwilling or unable to provide the amount of authorized services as requested by the ISP and /or physician order, and the client, despite the full assistance of the Care Coordinator and the Department of Health Care Services, is unable to arrange for another waiver service provider; and/or,

(viii) The client is unable to maintain health, safety, and/or welfare in the assisted living setting as determined by the CCA in conjunction with the resident, the RCFE or HHA, the resident's physician, and/or others as appropriate.

(b) When waiver services are denied, reduced or terminated, a notice of action will be forwarded to the client by the Long-Term Care Division of DHCS in conformance with Title 22 §50952 and §51014.1.

(3) Procedures for terminating services

In the event that a provider is no longer capable of meeting the needs of an ALW client, the CCA, in conjunction with DHCS, assists in the emergency relocation of the client if necessary and/or in securing another provider to meet the client's needs.

ALW providers may not discharge a resident simply because the resident requires care at a higher service tier. Providers are expected to serve residents at all service levels unless they exceed the admission/retention criteria. Providers must receive the approval of an ALW resident's CCA and DHCS before initiating any termination or discharge procedures.

If an ALW client voluntarily chooses to withdraw from the ALW, the client should contact his/her CCA to initiate the withdrawal process.

Any deposits paid for with waiver monies must be returned to Medi-Cal when the beneficiary leaves the PH residence. These monies are reimbursed to the Utilization Management Division.

(4) Right to a Fair Hearing

Beneficiaries must be given written notice by DHCS at least 10 days prior to action by the Department that denies, reduces or terminates services. Upon receipt of written notice, beneficiaries have the right to appeal the

intended action of the Department through the Fair Hearing Process as per Title 22, CCR 51014.01.

4. CARE COORDINATION

A. Introduction

CCAs are expected to coordinate ***the entire*** waiver, State Plan, and community resources needed to enable a client to continue living in the community. Services are delivered pursuant to an assessment and the development of a service plan. Service provision is routinely monitored and clients are reassessed every six months.

B. Description of Care Coordination Process

The Care Coordination process includes the following activities performed in the order in which they are listed.

(1) Receive referral or find case as a result of outreach activities;

(2) Screen to determine whether to conduct an assessment;

(3) Verify Medi-Cal eligibility;

(4) Conduct assessment;

(5) Determine tier of care:

(6) Choosing the ALW;

(7) Develop the Individual Service Plan;

(8) Send assessment and ISP to DHCS to enroll client;

(9) Client is enrolled in the ALW;

(10) Selection by client of a participating RCFE or PH that has a contract with a participating HHA. Transition to the PH or RCFE if necessary;

(11) Arrange for services;

(12) Monitor service delivery;
If appropriate based on Care Plan, the Contracted Care Coordinator will physically observe private rooms that are required to be provided by the RCFE waiver provider that include:

a. Private or semi-private full bathroom (shared by not more than two beneficiaries);

b. Shared common space, such as a dining room, parlor or common activities center that may also serve as a dining room;
c. Kitchenette, equipped with a refrigerator, a microwave (or cooking appliance) and adequate storage space for utensils and supplies;

(13) Conduct Reassessment.

This process is modified slightly for clients who seek to transition from a nursing facility to an ALW RCFE or PH site. See Section (K) for a description of the transition process.

C. Outreach and Case Finding

The purpose of the outreach effort is to inform the community of the existence of the program, and establish working relationships with sources of referral. Outreach and case finding efforts will be undertaken by Care Coordinators who will develop tools and materials specific to the needs of the county in which they operate. It is envisioned that Care Coordinators will establish continuing contact with a number of community entities including:

- Discharge planners in acute care hospitals;
- Discharge planners in long-term care facilities;
- County-based In-Home Supportive Services (IHSS) programs;
- Medi-Cal Field Office staff;
- Home Health Agencies (HHAs), social service agencies, physicians and other home health a community providers; and
- Potential clients and their families.

The referral process may also be initiated by RCFEs, HHAs or staff from PH sites who contact a Care Coordinator Agency.

D. Screening Prior to Assessment

The purpose of the screening process is to screen out community residents who do not require NF level of care or require more care than can be provided in the ALW. Screening allows the Care Coordinator to use his/her time more efficiently.

The screen helps the CCA determine if a potential participant is either so clearly not able to meet the NF LOC designation or so debilitated that there is no reason to conduct an assessment. An example of the former is deciding not to conduct an assessment of an individual who doesn't have any ADL deficiencies. An example of the latter is deciding not to assess a potential client who has one of the conditions listed in Chapter 2 Section C5 that automatically renders that individual ineligible for the project. Screening does **NOT** determine a potential client's level of care. The

determination of a client's LOC can only be made by administering and scoring the Assessment Tool.

E. Verifying Medi-Cal Eligibility

Verification of client eligibility can be obtained from the following sources:

- Medi-Cal Eligibility Data System (MEDS) screen print;
- Certification from the Claims and Real Time Eligibility System (CERTS) or the Automated Eligibility Verification system (AVES). Both of these systems are available to Medi-Cal Providers through the Medi-Cal Fiscal Intermediary,ACS-Xerox;
- A county issued immediate need Medi-Cal card or sticker

A copy of the document used to verify eligibility must be sent to DHCS in order to enroll a client in the project.

Applicants who appear eligible for Medi-Cal, but are not receiving benefits, should be referred to the county welfare department for Medi-Cal eligibility determination. Individuals already receiving SSI/SSP are automatically eligible for Medi-Cal as arranged by the local Social Security Administration office.

Once the applicant has been enrolled in the Medi-Cal program, CCAs may proceed with the enrollment process.

CCAs are responsible for continuing to verify client eligibility each month. This verification must be completed by the first of the month.

F. Conducting an Assessment

(1) Purpose

Assessment is the foundation of the care coordination process. It is the means by which problems and service needs are identified and level of care is determined. Assessment precedes enrollment. Until the applicant is assessed and a service plan is developed, s/he cannot be enrolled in the ALW.

The outcome of the assessment is a determination of:

- ✓ The client's LOC and capacity to live independently and
- ✓ The services needed to safely sustain residence in the community with as much independence as possible.

(2) Process

The assessment requires a face-to-face interview with the client and, as appropriate, contact with the family, legal representatives and/or other informal supports. Clients and family are expected to remain involved in the assessment and service planning process.

The R.N. Care Coordinator must conduct the assessment using the ALW Assessment Tool. S/he may be assisted by the Social Services Care Coordinator. **ALL QUESTIONS ON THE ASSESSMENT TOOL MUST BE ANSWERED.** Points are assigned to the applicant based on the response to specific questions. The number of points determines the applicant's LOC. If a question is not answered, this may affect the individual's score and their eligibility to enroll in the ALW.

The ALW Assessment Tool User Manual provides information about how to complete the Assessment Tool.

The Assessment Tool **MUST** be signed and dated by everyone participating in the assessment process.

G. Determining Level of Care

(1) Overview

The LOC is determined by the assessment. The scoring process is automatic. The letter associated with a response to certain questions is entered into an Excel spreadsheet, which then automatically calculates the participants tier or level of care. For example, If the response that best characterizes the information requested in question B.2 is "c" then "c" is entered into the spreadsheet. Excel automatically converts the response, "c" into a number. Excel tabulates all of the numbers and arrives at the final score. The score corresponds to a tier or LOC.

(2) Description of Service Tiers

Tier one applies to participants with the lowest level of support need; tiers two and three apply to residents with more significant support needs, respectively. Tier four services are provided to residents with the most intense support needs.

(3) Reassessment Schedule

The CCA is responsible for reassessing each client every six months or upon significant changes in condition. A new level of service (tier) is determined at this time.

H. Choosing the ALW

Once the applicant has been determined to need NF level of care, CCAs are required to provide prospective clients with information about nursing home care and community-based alternatives to NF care. CCAs **MUST** tell applicants that they have the **RIGHT** to choose residence in a nursing facility, consider other HCBS waivers, or enroll in the ALW.

CCAs must also provide the client with copies of the Freedom of Choice Letter and the Freedom of Choice Document. The client **MUST** sign the Freedom of Choice document, which verifies that information about community-based alternatives to nursing homes has been provided and the client has chosen to participate in the ALW. ***The signed and dated original Freedom of Choice document must be retained in the client's file***.

I. Developing the Individual Service Plan

(1) Purpose

Once clients have documented their choice to participate in the ALW, the CCA develops a plan that addresses identified problems, outcomes to be achieved, and services to be provided in support of goal achievement. It provides a focus for the needs identified in the assessment; it organizes the delivery system for the client; and it helps assure that the services being delivered are appropriate to the problem. There should be a clear link between the assessment tool, the problem, and the services provided to resolve the problem.

(2) Process

The outcome of the service planning process is a completed ISP, which is then implemented by the CCA. **ALL** of the information on the ISP is required. Each line or box **must** contain the requested information.

- Fill in the client's name, address, telephone number, and Medi-Cal number.
- Specify whether this ISP is an initial plan or an update. If update, provide the date of the last ISP.
- Specify the tier of service when the last ISP was completed.
- If the ISP is an update, specify the reason for completing another ISP—either as part of the semiannual reassessment or because the client has experienced a significant change in care needs.
- Fill in the dates during which this ISP is in effect. The ISP is operative from the date of the assessment until 6 months after the date of the assessment.

- Specify the tier of service the client will receive as determined by the just-completed assessment.
- Based on the just-completed assessment identify the problems or needs of the client. Enter that information in the **Problem** box.
- Specify the intervention or service that will be provided to address the problem of need. Enter that information in the **Intervention** box.
- Specify the goal of the intervention and enter the information in the **Goal** box.
- Specify what you would like to have happen as a result of the client receiving the service or intervention. Enter that information in the **Outcome** box.
- Enter the **Provider's name and phone number** in the appropriate box.
- Enter the **date** services are expected to begin and the date they are expected to end if the service is time limited as opposed to ongoing.
- Specify the funding source for the service if the service is not a waiver benefit. For example, the service may be paid for by Medi-Cal state funds or provided without charge by a community-based non-profit.
- ***The client must be an active participant in the development of the service plan and must indicate her involvement by responding to the assurances on the last page of the ISP.***
- If the client disagrees with part of the plan, the resolution of the disagreement must be noted on the ISP.
- ***The client must receive a completed copy of the plan and must check the Yes box indicating receipt of the plan.***
- All members of the ISP team must be listed as participants.
- ***The plan must be signed and dated by the Client, Social Services Care Coordinator and RN Care Coordinator.***

The ISP is operative until six months after the date of the assessment or until the client experiences significant changes in his/her condition necessitating reassessment and the development of a new ISP.

Copies of the ISP are also provided to the RCFE or HHA delivering services to the client and to the client's family or guardian as appropriate.

J. Enrolling the Client

To enroll a client, the CCA must submit to DHCS the name of the enrollee, the enrollee's completed, signed, and scored Assessment Tool, a signed Freedom of Choice document, and the client's completed and signed ISP. ***THE CLIENT CANNOT BE ENROLLED UNTIL THESE DOCUMENTS ARE COMPLETED AND FAXED TO DHCS.***

The completed Assessment Tool, Freedom of Choice document, and ISP must be faxed to DHCS. DHCS will fax notification of enrollment to the CCA. DHCS will also send an Informing Notice to the client. The Informing Notice details the roles and responsibilities of the beneficiary, the CCA, the provider and the physician.

It is important to complete the Assessment and develop the ISP as promptly as possible. Clients cannot be enrolled until the documents are completed and faxed to DHCS and all clients must be enrolled into the Assisted Living Waiver prior to billing.

K. Transitioning to an RCFE or PH Site

(1) Clients Residing in the Community

CCAs should help clients who want to transition to a participating RCFE to find an appropriate facility. Similarly, CCAs should help clients who want to transition to a PH site served by a participating HHA. Family members, friends or legal representatives should be encouraged to visit the facility or housing site with the client to determine if the facility or housing site is appropriate.

RCFEs are not required to accept every ALW client who selects their facility, although they may not exclude clients because their level of care is "too high". All ALW service providers are required to serve residents at all service tiers. However, facilities may choose to not accept clients who have needs that would likely not be best served in that locations (e.g., a client who has a history of dedicated wandering in a facility located on a busy street with fast-moving traffic.)

Once the client has made a decision to move to a facility, the client or her legal representative is responsible for the actual move, but they should be assisted, if necessary, by the CCA to find additional resources to facilitate the move.

(2) Clients Residing in a Nursing Facility

One of the goals of the ALW is to transition nursing home residents from the nursing facility to either an RCFE or a PH site. Two features of the ALW are designed to support the transition.

(a) One Time Only Payment to CCAs

CCAs are eligible to receive a one-time payment of $1,000 for every enrolled client who is transitioned from a nursing facility to a community

setting. This allows CCAs to begin working with clients who are interested in moving in advance of the actual move and before they have been enrolled in the program.

Medi-Cal recipients who are currently residing in a nursing home meet the eligibility requirements. Therefore CCAs can begin working on the transition as soon as the client expresses an interest in enrolling in the ALW as an alternative to continued residence in the facility. The Assessment Tool and ISP must be completed before the client is enrolled, and CCAs can only be paid **AFTER** the client is enrolled, but work to facilitate the transition can begin in advance of actual enrollment.

When CCAs submit bills on behalf of a vendor, they must submit an invoice detailing the date the work was performed, the scope of the work and the amount due. If the work is billed on an hourly basis, the scope should include the number of hours worked. The ISP showing the need for the service should accompany the invoice.

L. Arranging for Services

CCAs are responsible for arranging for the provision of all needed services as identified on the client's ISP. This includes all waiver benefits, all Medi-Cal State Plan services and all services provided by community resources. CCAs should refer clients to service providers identified on the ISP and record the start and, if appropriate, end date for services.

M. Monitoring Service Delivery

(1) Purpose

Monitoring service delivery is accomplished through contact with the client. The primary purpose of the contact is to determine if the services that are being provided to the client are meeting his/her needs and whether the client is satisfied with the services being provided. During this period between assessments, when services are being provided and monitored, the CCA should be informally and continuously assessing and evaluating the necessity and appropriateness of services. If for some reason, the services are not meeting the client's needs, the ISP should be amended and appropriate services should be initiated. These changes must be documented in the Progress Notes.

(2) Minimum Schedule of Contact with Clients

- Face-to-face visit a minimum of every 30 days.

- When client is in a SNF or acute setting, in order to bill Medi-Cal a face to face meeting is recommended with either/or the client, family or advocate. If a face to face meeting cannot be conducted; documented evidence of contacts (phone or electronic) with family/advocate or medical professionals currently caring for the client must be submitted to the ALW office for approval.
- Assessment visit every 6 months or upon significant change.

All contacts must be documented in the Progress Notes.

(3) Complaints

All complaints from clients, a member of their family, or friend, about service provision by any provider must be forwarded to DHCS within 24 hours of receipt.

Receipt of a complaint from a client or other individual on behalf of the client should be documented in the Progress Notes.

(4) Signs of Abuse or Neglect

If a client exhibits any sign of abuse or neglect, contact the Ombudsman (if the client is a resident of an RCFE) or APS (if the client is a resident of PH) immediately. Such events must be documented in the Progress Notes as well as required to be submitted through a Special Incident Report (SIR), to the DHCS.

Forward information about the referral to DHCS immediately.

(5) Reporting Requirements for RCFEs and HHAs

RCFEs and HHAs participating in the ALW are expected to comply with all reporting requirements mandated by licensing regulations. Both are also expected to forward copies of incident reports submitted to the licensing agency to the participant's CCA. Similarly, both are required to forward to the CCA any concerns expressed by a resident, the resident's family and/or others that indicate the resident may be at risk. CCAs are expected to document receipt of these reports in the Progress Notes.

N. Reassessment

(1) Timeline

Reassessments are performed every 6 months or when the client experiences a significant change in condition.

(2) Process

CCAs must conduct the assessment using the ALW Assessment Tool. **All** of the questions must be reviewed and the responses updated as appropriate. The Assessment Tool will determine the client's new level of care. A new ISP must be developed and the updated level of care must be recorded on the new ISP.

The updated Assessment and ISP must be faxed to DHCS.

5. RECORDS AND DATA COLLECTION

A. Recording Progress Notes

CCAs must document all contacts with the client and all activities performed on behalf of the client. All notes must be signed and dated. The note should record the date and time of the contact, the mode of contact, for example, telephone conversation or interview, and pertinent information about the client's health and psychosocial status and subject's discussed. All activities performed on behalf of the client, for example speaking with a service provider about the timing of the service, must also be documented.

CCAs must document a client's refusal of services. The note should describe the reason for refusing service as well as the date the service was refused.

B. Confidentiality

The names of persons receiving services through the ALW are confidential and are protected from unauthorized disclosure. All client-related information, records and data elements must be protected by service providers from unauthorized disclosure.

C. Data Collection

The AL Waiver program is a federally funded project. DHCS is responsible for preparing and submitting routine financial and performance data to CMS...

The Assessment Tool and ISP will provide data to DHCS. A log of complaints that DHCS maintains based on the reports submitted by the CCAs is another source of data. All of the information gleaned from the quality assurance audits is also a source of data as is the client satisfaction survey completed by participants. ***ACCURATE AND COMPLETE DATA IS ESSENTIAL TO THE ALW.*** The CCAs must provide all required data to DHCS in the specified time frame.

D. Storage of Records

Each participating CCA is responsible for maintaining and storing all information obtained on each ALW client for a minimum of three years.

6. QUALITY ASSURANCE

A. Care Coordinators' Role in Assuring Quality of Care

The CCAs play an important role in the ALW Quality Assurance Plan. Care Coordinators are responsible for:

- ✓ Verifying Medi-Cal eligibility on a monthly basis
- ✓ Monitoring clients through regularly scheduled contacts
- ✓ Forwarding complaints to DHCS
- ✓ Informing DHCS when an Special Incident Report (SIR) and an abuse report is submitted to APS or the Ombudsman

In addition Care Coordination Agencies are required to develop and maintain a quality assurance plan to track the following:

- ✓ Special Incident Reports (SIRs) and complaints
- ✓ Required staff training
- ✓ Contingency plans(s) to provide services in case of a disaster or emergency where the scheduled staff is not available.

B. Opportunities for Client Feedback

The CCAs are required to provide clients with opportunities to offer feedback regarding their level of satisfaction with services. An example of such opportunities includes satisfaction surveys or suggestion boxes.

C. Audit of Care Coordination Records

DHCS is responsible for quality assurance for the ALW. The State will conduct an annual audit of a random sample of client records. A minimum of ten percent of a Care Coordination Agency's charts will be reviewed. The audit will examine whether:

(a.) The ALW Assessment Tool was completed and scored for all enrollees in a timely manner

(b.) The file contains documentation that the client has received an explanation of the options and services available

(c.) Review any/all SIRs for completion and follow up and resolve of incident or situation.

(d.) The ISP has been personalized, meets the client's needs as identified in the Assessment Tool, and has been approved by the client

(e.) The Progress Notes document client contacts as required, record the client's health and psychosocial status and satisfaction with the project, and note any refusal of service

(f.) The Progress Notes document the date, time and duration of the contact.

At the conclusion of the audit DHCS will identify problems and may suggest remediation actions. A re-audit of charts must confirm that the remediation efforts were successful.

The CCAs that do not perform to standard will be discontinued as ALW providers.

7. BILLING

A. Arranging Payment for Vendors

Providers have the right to enroll in the Medi-Cal Program or have the CCAs submit bills on their behalf. If you submit a bill on behalf of a vendor, you should following the process outlined in B. (2).

When the CCA submits a bill on a UB-04 form on behalf of the vendor, they must also retain the invoice from the vendor that specifies the following:

- The service provided
- The procedure code for the service
- The dates of service
- The number of units or hours of service provided
- The rate per unit
- The total charge
- The ISP reflecting the need for the service
- A copy of the inspection clearance if the work is for environmental modification and the work required a building inspection.

B. Billing

(1) Overview

ALW providers will bill ACS-Xerox directly using the **UB-04** billing form. A Treatment Authorization Request (TAR) is **NOT** required.

Only providers enrolled in the Medi-Cal system can successfully submit claims for service and providers may only bill for clients already enrolled in the ALW.

(2) Process

(a) You must submit a UB-04 form for each participant. Complete the following fields on the form. Leave the other fields blank.
Field 1 Enter your organization name and address, including ZIP Code
Field 3 This is an optional field, creating a participant control number that will help you identify a participant should you ever need to follow up with a concern regarding your UB-04. Your office's participant record number is a common choice for this field.

Field 4 Enter the number "**331**". (Outpatient Health)
Field 12 Enter the participant's last name followed by the first name
Field 13 Enter the participant's address including ZIP code
Field 14 Enter the participant's birth date in an 8-digit format starting with the month (2digits), day of the month (2 digits) and year (4 digits): Example – mm/dd/yyyy.
Field 42 Enter the code "001" on the last detail line (line #23) to designate the total charge line.
Field 43 Enter description of services. At the bottom of this field, in line 23 enter "Total Charges" in the white box.
Field 44 Enter the HCPCS code on the red line (line #2). The codes are:

Care Coordination	G9002
NF Transition Care Coordination	G9001

Field 45 Enter the service dates in a from/through format. Enter the start date for the month on the white line (line #1) and the end date for the month on the red line (line #2).
Field 46 Enter the number of units of service provided during the billing period on the red line. Care coordination is 1 unit of service.
Field 47 Enter the charge corresponding to the service provided on the red line (directly across from the end date for service. At the bottom of the column, line 23, enter the total charge for the month.
Field 50 Enter "O/P Medi-Cal" on line A.
Field 51 Enter your 9-digit alpha numeric Medi-Cal provider number.
Field 60 Enter the 14 digit Medi-Cal BIN number (or the 9-digit CIN number).
Field 84 Only use to indicate attachments (rare), or to indicate the patient is over 100 years of age.
Field 85 Sign and date the form in black ink only.

(b) Invoices are submitted to:
MEDI-CAL
Fiscal Intermediary, ACS-Xerox
P.O. Box 15600
Sacramento, CA 95852-1600

(ACS supplies envelopes free of charge upon request)

(3) Contacting ACS

The ACS Provider Training Unit coordinates and conducts numerous Medi-Cal training seminars that benefit both new and experienced billers. Held in various cities throughout the state, these seminars target providers and billing staff who are either new to the Medi-Cal program or who have specific Medi-Cal billing questions.

Training seminar dates and locations are published on this Web page and in the *Medi-Cal Updates*. We encourage you to bookmark this page and refer to it often for the most current information.

http://files.medi-cal.ca.gov/pubsdoco/eo/training.asp

For your convenience, you may also schedule a custom billing workshop throughout the year. To schedule a custom workshop, call Medi-Cal at 1-800-541-5555 and tell the agent you would like to be contacted by your Regional Representative. If you need help completing the UB-04, you can call the Provider Support Center at 800-541-5555.

ACS also maintains a Small Provider Billing Unit, a free, full-service billing assistance and training program. Claims processors and regional field representatives work directly with providers in a structured program to assist in completing and submitting Medi-Cal claims. This detailed training program lasts one year. To qualify, you must submit no more than 100 claim lines per month. To contact this unit call (800) 541-555 ext 1275 or call 916-636-1967.